VOL. 15, NO. 2 JULY-AUGUST, 1965

Inventory

A BI-MONTHLY JOURNAL ON ALCOHOL AND ALCOHOLISM

PUBLISHED BY THE N. C. ALCOHOLIC REHABILITATION PROGRAM

TREATMENT

REHABILITATION

EDUCATION

PREVENTION

N. C. ALCOHOLIC REHABILITATION CENTER

BUTNER, N. C.

About the Center . . .

The A.R.C., as it has come to be known, is a 50 bed in-residence treatment facility for problem drinkers. Located at Butner, N. C., a small community approximately 12 miles north of Durham, N. C. off Highway 15, it is operated under the authority of the N. C. Department of Mental Health. The Center provides residence, treatment and workshop facilities for 38 male and 12 female patients.

A.R.C. Treatment Methods . . .

Treatment is by psychotherapy and consists of group discussions led by the professional staff, educational films, individual consultations with staff members, vocational guidance, recreation, rest, proper food and prescribed medications.

Length of Stay . . .

The basic treatment program is based on a 28-day schedule. The patient may remain for a longer period if, in the opinion of the staff, it will be of further therapeutic benefit to him. No applications for less than 28 days are accepted.

Admission Requirements . . .

1. Persons desiring admission must come voluntarily. No one can be admitted by court order. The individual who is sincere in wanting help and who comes voluntarily stands a much better chance of successful rehabilitation.

2. An appointment for admission is obtained by written or telephone application to the Admitting Officer, 406 Central Ave., Butner, N. C. (telephone 919 985-6770). All appointments are confirmed by mail. Preferably they should be made through a physician or other professional person in the prospective patient's community.

3. Since the Center is not designed, nor equipped, as a sobering up facility, the prospective patient must not have taken any alcoholic beverages for at least 72 hours prior to admission.

4. A report of a recent physicial examination by a duly licensed physician must be presented prior to or at the time of admission. The prospective patient's physical condition must be reasonably good enough to enable him to participate fully in all phases of the treatment program. There are no medical beds for the treatment of serious physical or mental disorders.

5. A fee of $75 in cash or certified check only must be paid at the time of admission. No personal checks can be accepted! Cases of true indigency must present written evidence in the form of a letter from their county welfare department at the time of admission or before.

6. A social history, compiled by a trained social worker in the local welfare or family service agency or other professional organization is required. Arrangements for the history should be made early enough so that it reaches the Center within a week following admission.

Admitting Days . . .

In order to facilitate the program of treatment by the small group method, prospective patients are admitted on Wednesdays, Thursdays and Fridays from 8 to 12 a.m. and 1 to 5 p.m. In this manner several days of adjustment to the life of the Center are provided before the beginning of the intensive treatment program the following Monday.

ALCOHOLIC REHABILITATION PROGRAM

OF THE

NORTH CAROLINA DEPARTMENT OF MENTAL HEALTH

NORBERT L. KELLY, Ph.D.
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INVENTORY

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RALEIGH, N. C.

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The void of the empty cup in the life of the non-drinking alcoholic must be filled if there is to be continued, happy sobriety.

THE ALCOHOLIC'S EMPTY CUP

BY ZANIE RUTH ADAMS, R.N.

SUPERVISOR, PUBLIC HEALTH NURSING
MECKLENBURG
COUNTY HEALTH DEPARTMENT
CHARLOTTE, N. C.

Mrs. Xanie Ruth Adams is a graduate of Queens College and the Presbyterian Hospital School of Nursing, Charlotte, N. C. She received her training in public health at William and Mary College, Williamsburg, Virginia.

WILL the attempt to change the face of alcoholism be clearly chiseled or will it become a caricature?

The answer to this question depends, to a great extent, on the tools and the understanding of the large and varied group of people working with the alcoholic. How wisely the tools are used depends upon how the workers feel about the non-drinking alcoholic with his *empty cup,* as well as the drinking alcoholic with his cup running over. Above all, what does the non-drinking alcoholic feel about himself and his empty cup?

Steve was an alcoholic and he knew it. He sat on the wooden steps that led to the second story two-room flat where he and his two children lived. He had thought to watch them play would allay his despondency. Truly a drink was what he wanted; he would have his cup running over. He stared at the swollen clouds. The air, sticky, hot and humid, seemed to settle upon him alone, making his tortured body, mind and soul feel as oppressive as the air about him.

He had stopped by a bar to get just one drink. He must have it. Life was intolerable, and he felt deeply the emptiness of his cup; his mind was a void; his soul empty. Then Martha, his wife, filled his thoughts. He had made her life miserable. Finally, she left him. Her parting note said, "Quit drinking and I may come back. Mrs. Lowe, the woman next door, says she will tend to the children." He did not condemn Martha. His own guilt was too consuming. So he left the bar without that one drink. Within him there was no willingness or joy at not taking the drink, only a profound feeling of being told *no*. To not take the drink may be the only way to get Martha back.

He went to his children, for here was surely love. The love he needed so much. Most people would judge Steve as a total failure. No job, no money, hardly a roof over his head. To his children he was the greatest thing in the world. They loved him without questions or demands. The three resting on the steps made a picture of love and affection. This we so often lose sight of in the alcoholic. He needs to *receive and give* love. He is considered immature; he may be loud, playing the clown. He is often shy, self-conscious. He has an ever present tendency to retreat rather than to continue to struggle with the uncertainties of life. He is sensitive and would give you the shirt off his back. He is often intelligent. He wants a beautiful world. What a pity, in trying for beauty, he makes tragedy.

$99,879,341 to North Carolina A.B.C. stores in 1963 for alcoholic beverages. True statistics on the number of alcoholics are impossible to come by for it is not a reportable disease. The high expenditure for alcoholic beverages indicates the possibility of a great number of alcoholics. It is estimated that we have five million in our nation and the figure is rising.

What causes alcoholic people (and they are very real people) to give up what they feel is their best friend? What motivates drying up the cup and keeping it empty—saint, sinner, savior, or self? Who knows? Causes of compulsive drinking and its cessation are still so unknown that it can hardly be guessed what process of change occurs. Change does occur and the alcoholic's cup is empty. There is a void within him. Herein lies the heart of the problem.

. . . The alcoholic needs help when his cup is empty, too.

Mind you, these are much the same characteristics of the drinking alcoholic. How unwise we are to forget that these same characteristics linger on when his "cup is empty." We must consider from whence he has come and where we expect him to go. Greater still, where does *he* want to go? We are prone to tell him how we feel about him, but not so eager to get him to say how he *really* feels.

The alcoholic is an ill person but there are those who still call him a drunk or a lush. There is a growing knowledge regarding alcoholism. This is good. Many people contend alcohol is fun, and so it is up to a point. Really the compulsive drinker would not have his cup empty for herein lies his crutch. Here is "release fun." It must be that we are a fun-loving people for we paid

His life, family, work, environment, are suddenly changed.

Now *who is he?* Many told him *what he was* and *who he was* when he was drinking. Sober, who really realizes his problems? How many think his problems much the same as when he drank? Who feels his emptiness? That terrifying void must be filled if there is to be continued, happy sobriety, and with it growth to the person he would like to be. Who really thinks he needs help when his cup is empty? After all he is not drinking and this is what society demanded. What now?

First, we who would help forget that the attention given him when he was drinking is now gone. We pass by the alcoholic with the empty cup. He needs us even more now, and we pass on the "other side."

(Continued on page 12)

Reactions to "Jellinek's Disease"

Dr. Shenkman's suggestion concerning relabeling of alcoholism to "Jellinek's Disease" is most interesting and at first impression also personally appealing. We will see who salutes it in the August issue of the *Newsletter*. Meanwhile keep me appraised of the reactions to the idea from your readers.

Gus Hewlett, Executive Secretary
North American Association of
Alcoholism Programs

Lights Up Room

While I can't agree entirely with all of the author's assumptions, the term "Jellinek's Disease" seemed to light up the room for me. Like many people in the field, I have been searching for some type of word (or words) to replace the despicable word "alcoholism." "Jellinek's Disease" is *it* as far as I am concerned. Of course, it will have to be batted around in the field a good bit.

Norman J. Pinardi, Director
Information Services
Florida State Alcoholic
Rehabilitation Program

Point of Diminishing Return

I am in hearty agreement with ridding the field of the term "alcoholism." I have become more and more aware of the negative reactions which our association gets with the use of this word not only with the medical profession but with the public as a whole. It has become a cold and impersonal and isolated term indeed.

Although the use of alcoholism has brought about some acceptance of the disease concept, I feel its use has reached a point of diminishing returns and that a new term or terms which would be more descriptive of the disease should be found.

Dr. Shenkman's term "Jellinek's Disease" has some merit for the reason which he states in the article. However, there is one minor thing which might make this unacceptable to the profession, notably that Dr. Jellinek was not a medical doctor. Certainly I agree that Dr. Jellinek is more deserving of this recognition than any other person in this field.

Generally speaking, I thought Dr. Shenkman's article was excellent. Give him my best wishes that his suggestions will be soon implemented by the responsible agencies and groups which he mentioned.

William J. McCord,
Program Director
South Carolina Alcoholic
Rehabilitation Program

Root Causes

I am in debt to you again for the copy of *Inventory* with Dr. Shenkman's article. I'm afraid that the day of naming diseases for people is over. The trend today is to bore down to the ultimate molecular mechanisms and root causes—PKU (phenylketonuris) is a good example of what I mean.

Norman A. Desrosiers, M.D.
Deputy Commissioner
West Virginia Department
of Mental Health

VOL. 15, NO. 2 INVENTORY JULY-AUGUST, 1965

ARTICLES AND FEATURES OF INTEREST ON ALCOHOL AND ALCOHOLISM

Anyone who takes one or two drinks daily should be aware of the possible threat of alcohol-dependency and that the dangers of alcohol are much greater than he likes to think.

An Approach to the Prevention of Alcoholism

BY WILLIAM B. TERHUNE, M.D.

NEITHER a prohibitionist nor a teetotaler, I seek to reduce the occasion for both. Food, water, fire and alcohol are part of man's life—any of these, uncontrolled, may destroy him. Can the *non-addicted* person drink, enjoy it, stay sober and not become alcoholic?

Since this is an approach to prevention, I shall not define the total alcoholic issue. What I have to say here is based on the intensive study of 1,500 alcoholic patients—8 per cent of the emotionally ill people treated in the Terhune Clinic, at the Silver Hill Foundation, New Canaan, Connecticut, over a period of forty years. The majority were privileged adults: engineers, professors, bank presidents, well-to-do housewives.

This article is published by permission of the author, William B. Terhune, M.D.; the *New York State Journal of Medicine,* where it was originally published under the title "Prevention of Alcoholism" in August, 1964; and *Harper's Bazaar,* where it was published in March, 1965, under the title "How to Drink and Stay Sober."

Editor's note: The author prefaces his remarks on the "alcoholic personality" with the statement that ". . . there is no evidence to support the theory of an alcoholic personality per se. . ." For the benefit of our "less read" readers, this means that not all people with characteristics ascribed to the "alcoholic personality" as the result of various psychological studies become alcoholics even though they drink, and that alcoholics are not the only people who possess these characteristics. Also, as Dr. Ebbe Hoff points out on page 29, "Many of the psychological characteristics of the alcoholics as observed clinically can be explained as a result rather than causes of the condition."

There were approximately as many women as men, chiefly in their middle years. They were given comprehensive physical, laboratory, psychologic and psychiatric tests. Most of them were diagnosed as alcoholic neurotic (psychotic and psychopathic patients were not accepted).

There are now more alcoholic neurotic patients than formerly. Many neurotic patients previously treated for hysterical reactions, psychosomatic complaints, neurotic depressions and anxiety states, return years later, and, although free of their former symptoms, have become alcoholic

neurotic. Overindulgence in alcohol is the new symptom, substituted for the old.

Alcoholism is now epidemic: 10 per cent of the population are alcohol-dependent and 5 per cent are alcoholic. The Boston Committee on Alcoholism reports that 3 per cent of the business and industrial community are alcoholics. The Moreland Commission reported in 1963 that this nation spends from 10 to 11 billions annually on alcohol, and that there is an ever-increasing rate in its consumption. The alcoholic population of New York State, alone, increases by 200,000 annually.

Three out of four alcoholic persons end up with broken homes, cease being productive, jeopardize their jobs and sometimes ruin the lives of their relatives. Existing in a minuscule, barricaded world of complete unreality, they surround and encase themselves in an alcoholic barrier of deceit, projection (blaming their difficulties on others and the outside world), excuses and threats. If the drinking is long continued, the result is often death by accident, organic deterioration or suicide. Statistics show that among people who regularly take as little as two drinks daily, there is a 15 per cent earlier death rate than among those who do not drink at all. Moreover, it has been found that non-drinkers are less often sick.

Physicians rarely investigate the question of alcohol consumption thoroughly enough when a patient presents himself for a medical check-up; and, if they do recognize potential alcoholism, they may lack the courage to disclose that unwelcome truth. When a man discovers that his wife has concealed the empty bottle of the sherry she opened yesterday, he has a job on his hands! But he is seldom willing to recognize—or face —the truth until the habit has become dangerously entrenched.

In spite of the loose talk about drinking to whet the appetite or to relax, or a little alcohol being good for the coronaries, alcohol is poor medicine—indeed, useless. Another harmful, popular concept regards alcoholism as resulting from sinfulness and lack of will power; these are actually the symptoms produced by the disease.

The Classification and Diagnosis of Alcoholism

There are six stages of alcohol usage:

1) The Moderate, Occasional Social Drinker—*no problem per se.*

2) The Regular Social Drinker—*who may be headed for trouble.*

3) The Alcohol-Dependent—*who is in the stage preceding alcoholism (and whose number is legion).* This condition varies in degree and is usually unsuspected. An alcohol-dependent is capable of running his business and holding a job. His marriage may remain intact, even though his drinking strains the matrimonial bonds. He has friends and maintains self-respect—*because the society in which he lives is itself, to an appalling measure, alcohol-dependent.* Being not greatly out of harmony with the social climate, the alcohol-dependent fails to recognize his dependency and considers himself a free man living a free life—whereas, actually, the bonds of addiction are closing in.

Among the characteristics of the alcohol-dependent are the following: a) He cannot have a good time without alcohol; it is a 'must' for golf, fishing, card-playing and social occasions. b) He usually drinks during the selling of his products or services in private business. Alcohol becomes a habit for business entertainment:

two to three Martinis before the business luncheon. c) He looks forward to a few drinks immediately after work, perhaps in the bar car on the way home. d) He has a marked tendency to drink 'on signal': lunch, dinner, fatigue, party, sex, boredom, frustration, bedtime.

Executives sometimes become alcohol-dependent to meet the grind of routine pressure; habitually, they must have alcohol to offset fatigue or worry, and for "stimulation," relaxation and sleep. It has been aptly said that the 'four horsemen' of the daily grind are anxiety, discouragement, frustration and fatigue: alcohol-dependency results when one employs alcohol daily in an effort to overcome them.

Many married women who drink too much begin to retreat from the society of others, lead badly regulated lives, and become inadequate to the ordinary requirements of domestic life. They are on the verge of the next classification—the addictive drinker. These women usually have completely unrealistic conceptions of life, marriage and how to meet responsibilities. A girl's training today seldom equips her to be a wife; she has merely a dreamy idea of marriage, and fails to recognize that it is at many points a technical business, and that its success depends primarily on the wife. There is much secret nipping among such women; sherry, Dubonnet and beer often lead to hard liquor, and the drinking habit insidiously progresses into addiction. Husbands say: "I really don't know when it started. I was shocked to come home and find her tight, and then gradually discover what was really going on."

4) The Addictive Drinker—*who is compelled by the force of habituation: the habit itself calls for alcohol, without other inner needs.* The nervous, glandular and metabolic alcoholic patterns have been established. Never underestimate the strength of long entrenched habit: interrupted for a few days or months, it is only lying low, to return with renewed, unbelievable vigor.

5) The True Essential Alcoholic—*in whom there is both a physiologic condition and a psychologically compulsive state.* There is no cure for alcoholism. By the time someone has become a confirmed alcoholic, many irreversible changes have occurred in organic functioning, metabolism, body chemistry and personality; once alcoholic, always alcoholic. The best that can be done is to educate and lead this victim into a state of 'non-drinking alcoholism' —which can be likened to a keg of dynamite that one small match is enough to detonate and destroy. Therefore, prevention offers the only hope; indeed, it is the ultimate answer to control of this destructive malaise of our society.

The essentially alcoholic person experiences continual distress, centered around his inner feeling of self-depreciation, self-hate, self-pity and guilt. He is in jail and he knows it, although he continually hopes for a miraculous reprieve through someone else's efforts.

He regresses to marked immaturity, expressed in rapid mood swings, childish rationalizations, denials, extreme self-consciousness and projection. Truly weakened in ability and power, his ego is diminished (the superego does not exist), and he bolsters it by fantasy and lies. Such a patient deviates greatly from social norms and eventually becomes completely isolated. His overall attitude becomes one of extreme egocentricity, leading to undersocialization, and, in turn, to fewer compensa-

(Continued on page 10)

EDITORIAL

A fictitious news release

NEWS BULLETIN:

NO RELIEF IN NATIONAL HEALTH CRISIS IS SEEN

No relief in the ten-day-old National Health Crisis is forecast as the number of victims of Jellinek's disease passed the 6 million mark today.

In urging participation in the Nationwide Prevention Program which was launched simultaneously with the declaration of the National Health Crisis, officials pointed out that for every case of Jellinek's disease from 3 to 5 other people are adversely affected—men, women and children who are closely associated with the victims.

On this basis it is conservatively estimated that 18 million Americans are directly affected by Jellinek's disease and the figure is growing. The individual's chances of being directly involved is one in 10.

Jellinek's disease is a progressive illness which results in death or insanity if not checked. The victim, however, is not the only one who suffers. The effects of Jellinek's disease on the family are particularly devastating, causing disruption of family living and even emotional illness among family members. Without outside help for the family, the children may be subjected to an emotional climate which is not conducive to healthy development. Society, too, suffers from the loss of individual talents and contributions consumed by Jellinek's disease and the many social problems surrounding the illness for which society must bear the burden.

Authorities say that the specific causes of Jellinek's disease have yet to be proved, but that they are embedded in a complicated interaction among psychological, biological and sociological factors. A common element is excessive ingestion of a potentially addictive chemical, C_2H_5OH, which is the basic ingredient of several popular beverages drunk in varying degrees by approximately 80 million Americans over 15 years of age.

Although C_2H_5OH in moderate amounts is not harmful to most people, about 1 in 15 of the 80 million who drink these beverages will develop Jellinek's disease.

Jellinek's disease in a few people may develop on the first exposure to C_2H_5OH, but for most victims it develops gradually after repeated exposure over periods of 5 to 20 years.

Scientists warn that there is no way at the present time to tell positively who among those who are exposed to C_2H_5OH will develop Jellinek's disease, and urge all who use it, for their own protection, to attend the special community classes being conducted at health departments throughout the nation as part of the National Prevention Program.

Because of the lack of knowledge as to why some who are exposed to C_2H_5OH develop Jellinek's disease and others do not, all users must be considered to be in the "high risk" group, one authority said. The special classes for this group will stress the nature of the chemical, C_2H_5OH, and the symptomatology of Jellinek's disease.

Jellinek's disease can be successfully treated even though the specific causes are not known, particularly if recognized in its early stages, but recovery is dependent upon teaching the patient how to live without the chemical crutch, C_2H_5OH. Early diagnosis and treatment is one of the main goals of the educational efforts with the high risk groups.

Attitudes of society toward the use of C_2H_5OH play an important role in the development of Jellinek's disease and govern to a large extent whether or not the victim seeks treatment. Ignorance of the **true** nature of Jellinek's disease may be **the** major

drawback in efforts to combat the illness.

Many victims, for instance, have been allowed to die without treatment because of the stigma placed on Jellinek's disease by society. The situation is analogous to that of tuberculosis before this disease was widely understood. Through ignorance, victims of tuberculosis were hidden away in a back room and left to die because "nice people just didn't get the disease."

To facilitate the eradication of misconceptions about Jellinek's disease, general classes for people who for various reasons have not been exposed to C_2H_5OH have been organized along with the classes for high risk groups. The combined approach is expected to result in a unified attitude among all segments of society toward the victim of Jellinek's disease as a sick person and provide a climate in which the present victims can seek treatment without fear of social censure and, hopefully, also help prevent future cases by erasing ignorance of the true nature of the illness.

Attendance at the meetings is, of course, voluntary, but with the nationwide campaign now underway which is being actively supported by all health agencies—governmental, quasi-official, voluntary and many private ones as well—it will be "socially unpopular" not to attend.

Officials stressed that while prevention is the main purpose of the National Prevention Program "we must not neglect present victims of Jellinek's disease and those who are affected by them." It is most urgent, they said, that the families of present victims participate in classes designed not only to educate them about Jellinek's disease, but also to help them with their problems. This approach working with families has been shown to be one of the more effective ways of actually helping the victim toward recovery.

Another facet of the Nationwide Prevention Program is specialized seminars for people in professions that have the skills to treat the various aspects of this psycho-social and biological condition—physicians, psychiatrists, psychologists, social workers, nurses, ministers and others.

Hospitals which do not now accept patients with Jellinek's disease for treatment are being approached in an organized program by those which do in an effort to gain 100 per cent hospital privileges for this sick segment of our society.

A small per cent of the total number of Jellinek's disease victims become problems in the area of law enforcement as a result of their condition. A national committee report is expected to be released soon which will recommend guide lines as to how the concept of rehabilitation can be substituted for punishment under our present laws. This applies for all victims of Jellinek's disease who are incarcerated in jails and prisons, even those whose offenses were something other than their disease. This approach is to be a stop gap procedure until such time as society is ready to change existing laws which punish a person for being sick, and provide treatment and rehabilitation instead. Hopefully, the National Prevention Program will hasten this day. The recommendations of the committee will be implemented in so far as possible through the joint efforts of law enforcement officers, clerks of court and judges along with city, county and state governments.

Basic to the long-range prevention effort is a revamping of school health curriculums and teaching methods which will hopefully be accomplished through specialized programs with school administrators and teachers. With an improved curriculum and approach to teaching health — mental and physical — the result should be a new generation growing up armed with the knowledge necessary for maintaining physical and mental health.

Closely associated are the family life workshops open to interested persons of all ages which will be conducted in most communities. These workshops will stress the importance of family life in personality growth and be geared to the prevention of emotional illnesses of all kinds.

National headquarters will issue periodic progress reports throughout the National Health Crisis. Meanwhile, you are urged to contact your local headquarters for information about the prevention activities in your area. Authorities cautioned against panic but stressed that the Jellinek's disease crisis will be alleviated only by concentrated effort over a period of time.

Editor's Note: This is a fictitious news release. No National Health Crisis has been declared and, unfortunately, there is no Nationwide Prevention Program coordinated as such. The exact number of victims of "Jellinek's disease" is not known but is estimated to be between 5 and 6 million. We chose the outer limits to lend emphasis to the editorial. C_2H_5OH is, of course, the chemical formula for ethyl alcohol found in the popular beverages, beer, wine and whiskey. "Jellinek's disease" is a substitute for the term "alcoholism" but its use in this editorial is not necessarily to be construed as an endorsement of "Jellinek's disease" as a replacement for "alcoholism." We could have used "psychosociobiolitis" or some other made-up term just as well and still accomplished our purpose. We have merely attempted to show how the major health problem, alcoholism, appears when stripped of the emotionally-charged and controversial implications of the word "alcohol" in our society. Perhaps it's time we dropped all prejudice and begin to work on the real issues.

tions and satisfactions. This is the vicious alcoholic circle.

6) The Physically and Psychologically Degenerated Alcoholic—*there are not many of these so-called 'drunks'; and, usually, they deny being alcoholic.* Most degenerated alcoholic persons are hidden from sight. Without alcohol, they would become human again.

The Alcoholic Personality

The application of measures for prevention requires an understanding of the alcoholic personality. Although there is no evidence to support the theory of an alcoholic personality per se, it has been found that certain types of people, who have been reared under specific circumstances, and live under particular conditions, are more vulnerable to alcohol than others. If and when recognized, these people should receive intensive prophylaxis designed to protect them against their predispositions.

For example, the following types of people may have an alcoholic personality structure: a) Children who grow up without love, and those who have cold, undemonstrative parents: the emotionally neglected and deprived children. b) Those who have been markedly undisciplined as adolescents. d) Those with a history of poor adjustment to school, work and social obligation. e) All who adjust badly to marriage. f) Those whose traits give evidence of irresponsibility and superficiality; of over-sensitivity and shyness; of marked passivity. g) Mild manic-depressives. h) Psychopathic personalities (alcohol is only incidental in their turbulent and dangerous lives).

Manson's valuable study shows that the alcoholic differs from the non-alcoholic in being subject to these seven noticeable characteristics: chronic anxiety; depressive fluctuations; marked emotional sensitivity; easily aroused feelings of resentment; a history of failure to complete social objectives; chronic feelings of isolation, frequently accompanied by self-pity; and poor interpersonal relationships. Both the family, and the family physician, should obviously be on the alert for anyone with these characteristics of the potential alcoholic.

Conditions Fostering Alcoholic Habituation

Among the special circumstances that breed alcoholic habituation, dependency and neuroses in alcohol-vulnerable people are: a) An absence of motivation in education, work and life. b) A situation of prolonged frustration with a sense of defeat, frequently accompanied by self-pity and justified anger. c) Marital maladjustments—the greatest single factor in alcoholic women. d) Having a physically, mentally or psychologically handicapped child to deal with. e) Prolonged illness. f) An absence of absorbing compensations, hobbies or effective sublimations. g) Any intensely unrewarding, competitive situation—such as trying to do a job for which one is unfitted. h) Chronic emotional stress. i) Prolonged physical stress. j) Fatigue, and true emotional or physical exhaustion. k) An empty or purposeless old age.

Prevention of Alcoholism

Many people have an unconscious resistance to recognizing, or to being told, that they use alcohol inordinately, and, at the same time, have a deep fear of becoming alcoholic. Anyone who wants to drink and stay sober must first be able to face the following questions squarely (some physicians already have made this inquiry into drinking habits a regular part

of their history-taking): How much alcohol do you consume? When? How often? What kind? Why? How long have you been drinking? Are you increasing the amount and frequency? Anyone who takes one or two drinks every day should be aware of the possible threat of becoming an alcohol-dependent, and that the dangers of alcohol are much greater than he wants to think.

Beyond a doubt, an alcohol-prone personality should secure psychiatric guidance before alcohol becomes a further complication. As a general measure, good working habits, sufficient rest, exercise (*particularly* exercise), and play are all conducive to the reduction of emotional stress. Thus, if one feels the need of a drink, try walking instead—for hours, if necessary! Also, if a person has no life purpose, he must find one. The variant emotional gales are strong, and the sudden explosive attacks of aggression, and the force of buried hostility, can destroy. But these hazards can be avoided, or weathered, if one has stability of direction, and a purposeful life, guided toward ideals.

Ten Commandments for the Prevention of Alcoholism

1. Never take a drink when you 'need' one.

2. Sip slowly and space your drinks: the second drink, thirty minutes after the first; the third, an hour after the second; and a fourth, only at your own risk—indeed, I say: never a fourth.

3. Dilute alcohol. Have a long, weak drink—not on the rocks, not straight, and never out of the bottle!

4. Keep a truthful record of the amount you drink. Don't take a drink every day. Be vigilant as to the amount of each drink, whoever mixes it: does it consist of one, two or three ounces of alcohol—or was it poured without measure, "just a wee drop?"

5. Never conceal the amount of alcohol you drink. Instead, exaggerate it. If you say you drink twice as much as you think you do, this will probably be nearly accurate.

6. Do not drink on an empty stomach.

7. Stop drinking 'on signal.' The signals are: 'luncheon,' 'on the way home,' 'before dinner,' 'before bed,' 'meeting people,' 'celebrating,' and 'to get me through.' Introduce a substitute for alcohol at these times: a big cup of hot, strong tea before dinner to refresh and energize you (mountain climbers drink tea, not alcohol); a bowl of hot bouillon before lunch in place of a Martini; a cup of hot Ovaltine at bedtime; and the habitual drinking of water. One who uses these beverages as alcohol substitutes will feel better, be a better companion and enjoy happier evenings. The use of even some of these measures will interrupt the habit of 'signal drinking.'

8. When tired or tense, soak in a hot tub and follow with a cold shower.

9. Don't take a drink to escape discomfort, either physical or mental.

10. Never, never take a drink in the morning, thinking it will offset a hangover.

Avoid alcohol dependency as you would the plague. It is insidious and, unless you are extremely vigilant, will steal up on you without your knowing it. A person is on his way to alcoholism when: alcohol has an effect on him that is stronger than usual; when he takes a drink as 'medicine'; when he drinks compulsively; and when he drinks against his better judgment.

When a person's body chemistry and psychological reactions become alcoholic, he has literally 'had' it. If

he continues drinking at all, he will become either an alcohol-dependent, or a true alcoholic. Once a person repeatedly becomes inebriated, he will never again, under any circumstances, be able to use alcohol safely, no matter how small the amount, because one drink demands another.

Summary

Every responsible man or woman should be deeply concerned about the steadily rising tide of alcoholism in this country. It is a malignant, dangerous and destructive disease. Factually, we live in and accept the alcohol culture. Primarily a disease of severely neurotic individuals, it is culturally contagious. 'The alcohol neurosis' is an appropriate designation. It is already of endemic proportions and rapidly increasing, especially among married women.

The number of alcohol-dependent people is shocking. Since it takes very little to make a neurotic person alcohol-dependent, the per capita increase in consumption is not a true gauge. Furthermore, it is not the amount of alcohol consumed that determines alcoholism. Regular use of only a little of it can produce an alcohol-prone personality. The disease process becomes fixed by virtue of the addictive mechanism, conditioned responses and psychological rationalization. Once established, alcoholism is an irreversible, organic-psychologic syndrome and is incurable—once an alcoholic, always an alcoholic, although many may become 'non-drinking' alcoholics. Therefore I repeat: prevention offers the sole solution. Only the individual who has learned to drink moderately, who never uses alcohol to escape difficulties and tensions, and who knows the safe technics of drinking, can use alcohol pleasantly and harmlessly.

THE ALCOHOLIC'S EMPTY CUP

CONTINUED FROM PAGE 3

No more dramatics. He's sober. In sobriety, though, there can be a great deal of darkness and confusion. We must somehow help him *know himself,* light his lamp, hold it high, and *truly be proud of himself before God and man,* not just because he is sober but because he is on a path to a greater and fuller life. Help him hold his lamp high and independently. Every one has a special need for some independence.

The greatest help of all is to know that one need never walk alone, and this we must impart to the non-drinking alcoholic. There is God—then there is his fellowman with whom he finds a common link and strength. This may be through Alcoholics Anonymous, the church, or family. Frankly, I think the greatest progress for steady handling of the empty cup comes through the understanding of the family, and faith. Faith is not just for a moment, but for a lifetime.

There is a saying by some that A.A. is a selfish program. I do not believe this. The closest person in my life has been a member of A.A. fifteen years. No slips, but like many of those who drank a fifth throughout the day, and a pint in the evening, certainly there have been problems. Selfishness is not the main problem. His tendency is to give, give, give. He believes that the most you have in this world is what you give away. This is unselfishness that builds for bigness. To develop big and beautiful things, we should work together with the non-drinking alcoholics as well as the drinking alcoholics. We must have that symphony of effort. When this is present there is a kind of music from the empty cup that comes out loud and clear.

A feature designed to help you keep posted on developments in the field of alcoholism.

ZIP CODE NOTICE: In compliance with the ruling of the Post Office Department, the mailing address of each subscriber to INVENTORY within the United States must show the zip code number. Miss Eleanor Brooks, circulation manager, requests that subscribers send this information to her at their earliest convenience. A post card will suffice. There is time for a gradual changeover but, eventually, addresses without the zip code number will have to be deleted from the mailing list. Address your post card to: INVENTORY, Box 9494, Raleigh, N. C. 27603. (When this notice appeared in the May-June, 1965 issue, our Zip Code number was wrong.)

RALEIGH, N. C.: Representatives of the North Carolina Department of Mental Health and the Alcoholism Programs of North Carolina met at Dorothea Dix Hospital July 23 to discuss mutual programs and problems. Thirty-one people attended: 9, Department of Mental Health; 14 members of APNC, representing the 22 local alcoholism programs in the State and the alcoholic rehabilitation program of the North Carolina Prison Department; 6, Dorothea Dix Hospital; and 2 members of the Alcoholism Committee of the North Carolina Board of Mental Health. Programs and problems in treatment and education were discussed. The two groups meet on a quarterly basis. The next meeting will be held in Sanford, N. C. in conjunction with the fall meeting of the APNC.

TOP OF THE WORLD LIST: The U.S.A. now ranks ahead of France as the nation with the world's highest incidence of alcoholism, according to recent statistics from the World Health Organization.

WASHINGTON, D. C.: The North American Association of Alcoholism Programs (NAAAP) has announced that it is extending membership to individuals in recognition of the fact that many individuals representing many professions have made significant contributions to its progress during the past 14 years. Benefits of individual membership include: A quarterly Newsletter containing information of alcoholism activities everywhere; **Selected Papers,** a publication of the proceedings of the annual meeting; annual directories of research activities and treatment facilities, to put you in touch with what's going on, where and by whom; special reports for and by members, containing the latest thinking in the field; and the services of the NAAAP office in answering your specific needs and requests. The annual individual membership fee is $7.50, a small amount to pay to stay in the mainstream of alcoholism activities. The NAAAP is an organization of official State alcoholism programs in North America. This is the first time membership has been extended to individuals.

BUTNER, N. C.: Robert J. Blackley, M.D., former director of the Davidson County Mental Health Clinic and native of Hamlet, is the new medical director of the Alcoholic Rehabilitation Center. A graduate of the University of North Carolina and McGill University where he earned his M.D. degree, Dr. Blackley interned at Germantown Hospital, Phila., and served his residency in psychiatry at N. C. Memorial Hospital, Chapel Hill. He is a former acting superintendent of Murdoch Center and served six years as assistant superintendent of John Umstead Hospital.

MANUAL ON ALCOHOLISM FOR SOCIAL WORKERS: The Education Division, N. C. Department of Mental Health has recently published a Manual on Alcoholism for Social Workers. This 88-paged manual is a compilation of articles selected specifically for their usefulness to social workers. With the exception of three contributions by physicians, the authors of the articles are, themselves, social workers. The aim of the division is to get a manual into the hands of every social worker in the State. The preface to the manual reads: "It is our belief that wherever there is a practicing social worker in whatever setting, there is also an opportunity to help an alcoholic or his family . . . We wish to reach them all."

RALEIGH, N. C.: Inventory belongs to the people of North Carolina who have supported it through tax funds for 14 years — first, as an educational tool of the North Carolina Alcoholic Rehabilitation Program and now, since 1963, within the Education Division of the North Carolina Department of Mental Health. This is why, from time to time, we'd like to hear from you, the people of North Carolina who receive **Inventory** free on request, as to what **Inventory** means to you. What do you think its benefits are, as an individual or as a professional person? In what ways do you use **Inventory,** as an individual or as a professional person? What improvements would you like to see made in **Inventory?** Really, it would be a big help to the staff of **Inventory** and to its future if you would write us at Box 9494, Raleigh, N. C. 27603.

INCREASE IN ALCOHOLISM ADMISSIONS: The National Institute of Mental Health revealed recently that the number of alcoholics admitted to state mental hospitals in the United States has increased markedly in the past decade. According to Dr. Stanley F. Yolles, NIMH director, a recent study indicates that one in seven newly-admitted patients is an alcoholic, an 18 per cent increase in 10 years. In nine states, he added, disorders associated with alcoholism lead all other diagnoses in mental hospital admissions.

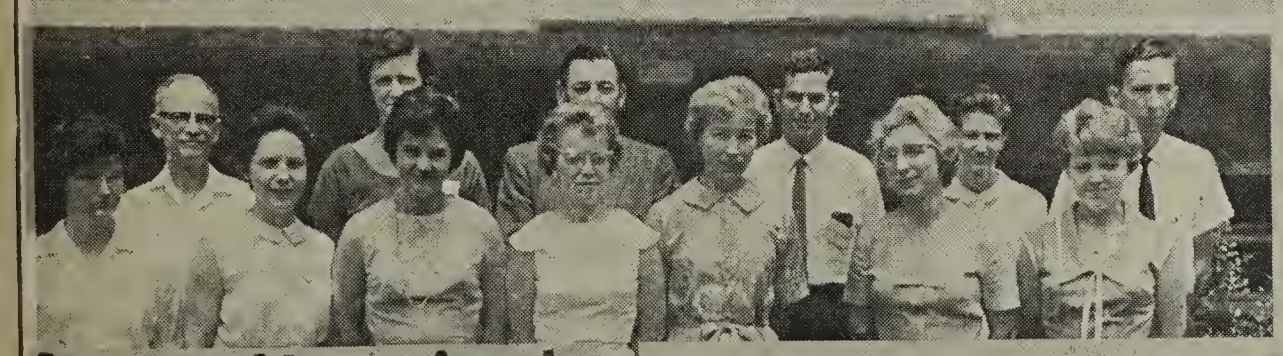
MIAMI, FLORIDA: Approximately 200 persons gathered in Miami May 1 to mark the second anniversary of the establishment of the City of Miami Alcoholic Rehabilitation Program. Speaking to those in attendance, many of whom had been rehabilitated through the court program for alcoholics, Senior Miami Municipal Court Judge Milton A. Friedman expressed optimism that the Miami program and similar projects will substantially diminish the "revolving door drunk" dilemma. Friedman said, "Our court program is being looked to as a leader in the field of rehabilitation for the chronic drunkenness jail offender. Inquiries are coming to us from all sections of the country. As a result of an April 23 meeting with U. S. Secretary of Health, Education and Welfare Anthony J. Celebrezze, judges from 40 states set a goal of 4,000 such programs throughout the country. Court programs such as ours are proving the effectiveness of offering rehabilitation for the drunkenness offender." Friedman explained that in the past two years between 50 and 62 per cent of arrested inebriates have not been re-arrested.—**Reporter,** Florida State Alcoholic Rehabilitation Program.

Faculty

1965 UNC SUMMER SCHOOL of ALCOHOL STUDIES

Ministers

Prison, Probation & Parole



State Hospitals

BY NORMAN J. PINARDI

DIRECTOR, INFORMATION SERVICES
FLORIDA STATE ALCOHOLIC REHABILITATION PROGRAM

The Miami program is helping to bring to the "drunk court" the qualities of mercy and justice which are often absent in dealing with chronic drunkenness offenders.

The Miami Court Program

FOR the past two years, the City of Miami Municipal Court System has been offering help to chronic drunkenness offenders in place of the perfunctory brand of "justice" which is typical of many municipal "drunk courts."

In the United States, every city of any size is faced with the dilemma of the alcoholic who becomes a chronic drunkenness offender. He (or she) spends a significant part of his adult life serving time in jail for being drunk in public. He is typically a skid-row or borderline skid-row resident, with no immediate family and few lasting friendships. He is usually unhealthy, frequently unclean and almost always ill-clothed. Because he is an alcoholic, drinking is an important facet of his everyday existence, and the intoxication which results is the "offense" for which he is jailed. It is not uncommon to find people with more than twenty arrests for public drunkenness *in one year*.

"Justice" is dispensed quickly and matter-of-factly in most "drunk courts," and because of the tenuous nature of the offender's position in the community there is little likelihood that he or anyone else will appeal if "justice" is somewhat summary in his case. Of course, the procedures followed always adhere to the letter of the law, if not the intent of the law. And if society lacks concern for the chronic drunkenness offender, it must be said that he lacks concern for himself.

The prospect of being jailed apparently carries little threat for him; jail is a normal part of life—something to be expected in the normal course of events. For some, it may even be a pleasant experience in comparison to the streets.

The important factor is that jailing an alcoholic does nothing to solve his problems or the city's problems with him. Realizing this, the Municipal Court Judges of the City of Miami set out to find a cure (or at least a treatment) for the dilemma of Miami's chronic drunkenness offender problem. It is altogether proper and fitting that the judges originated and spearheaded the attack on the problem. They are faced with the task of maintaining the qualities of justice and mercy while administering the laws of the City of Miami as they pertain to the hundreds of men and women who funnel through the courts every week.

The judges, acutely aware of the lack of purpose and the absence of justice in most "drunk courts," called in the Florida Alcoholic Rehabilitation Program to help formulate a pilot project which would inject a positive note in the situation. The agency provided consultation and other services to the judges, and later extended a scholarship for one of the judges to attend the Yale Summer School of Alcohol Studies. The ARP then extended a $5,000 matching-funds grant-in-aid to the City of Miami to hire a probation officer and underwrite the other costs of a program to offer help to Miami's chronic drunkenness offenders. The progress made by the Miami project with a small investment is an encouraging note for ARP officials. Almost every large community in Florida can afford a $5,000 to $10,000 investment.

The rehabilitation program developed in Miami is designed to offer help to anyone arrested for public drunkenness who professes an interest in doing something about his drinking problem. It became evident early in the project that the daily case load and duties of the probation officer would be immense, and that he could offer only a modicum of counseling to the chronic drunkenness offender. This meant that other local resources would have to become intimately involved with the effort, and one of the continuing major contributions to the project has come from the men and women of Alcoholics Anonymous in Miami who freely offer their time and services to bring the A.A. program to chronic drunkenness offenders.

Two Programs

Two specific programs have evolved over the past two years. One, known as the "court program," calls for 90 days of probation with required attendance during the probationary period at a Saturday morning meeting about alcoholism and community resources. The other, known as the "C-4 program," calls for a jail sentence to a special rehabilitation barracks in the City Stockade. The barracks features a full program of counseling, group therapy, vocational rehabilitation service, pastoral counseling and daily meetings about Alcoholics Anonymous.

It is a strange paradox that a rehabilitation process begins when someone is picked up off the streets of Miami, brought to the city jail, and booked for drunkenness. The first step in the process is a dismal 20′x30′ "drunk tank" with concrete floors and no furniture. At the end of the average day, the "tank" is filled to capacity with intoxicated people, all uncomfortable, some

retching, many with "the shakes."

After four hours—an arbitrary time period which permits some sobering up—they are moved from the "tank" to a more typical jail cell with a number of other drunkenness offenders to await trial. Those with $25 to their name usually bail themselves out at the end of the four-hour period and never appear in court. At this stage in the process the lot of the chronic drunkenness offender in Miami is no different from any other community.

Here, however, all similarity ends. Toward the end of each day, one of the two probation officers assigned to the chronic drunkenness offender program obtains the arrest records for everyone arrested that day. The following morning, all are brought to the auxiliary courtroom, where one of the probation officers addresses the group, discusses alcoholism and some of its symptoms, and encourages them to admit they have a drinking problem and to do something about it. He also explains briefly what the court is doing to offer them help. Then he calls up each person, one at a time, to briefly discuss his case and to encourage him to take advantage of the rehabilitation program. Only those who voluntarily request help in doing something about their drinking problem are recommended for one of the two court programs.

Later in the day, the entire group of persons arrested the previous day go before the judge in court. Along with their previous arrest record, the judge receives the results of a pre-sentence investigation prepared by the probation officer, and the recommendation of the probation officer. The judge, in contrast to most other "drunk courts," spends at least a few minutes time with each person discussing his case. The judge

The effort is in keeping with

then makes the ultimate decision as to whether to permit the individual to participate in one of the rehabilitation programs, and which course of rehabilitation to use. Usually, he relies heavily on the probation officer's pre-sentence investigation and recommendations.

Those who are sentenced to the stockade to participate in the C-4 program are moved from the courtroom to the stockade as quickly as possible. Those who are placed on 90-day probation to participate in the court program wait in the back of the courtroom until the judge has completed the day's work load. Then the probation officer explains the program more fully, and gives them tips on places where they may obtain free meals, where they may find work, temporary sleeping quarters, etc.

The Saturday morning meeting usually features a talk by one of the probation officers and a visiting member of Alcoholics Anonymous, who explains the A.A. recovery program, answers questions, etc. Other community resources are explained, and sometimes representatives of various agencies also speak and answer questions.

The probation officers are well aware that a Saturday morning meeting is not the answer to the problem of the individuals participating in the program. Utilization of community resources to obtain temporary daily sustenance, a roof over their heads and a job, and attendance at A.A. meetings are basic requirements for sobriety for most, and the counselors do everything possible to see that the people participating in the court program make use of every available resource. For the most

part, however, the participants are pretty much on their own during the 90-day probation period.

Those who find jobs which make it impossible to attend the Saturday morning meetings may attend a special Tuesday night group formed for this purpose. The meeting place is a long walk from the downtown areas where most of the participants live, but attendance averages 75-100, and has hit 250 on occasion. These Saturday morning meetings, coupled with the everyday cooperation of many community resources, provide the incentive and support needed to help many chronic drunkenness offenders out of the revolving door. Some, however, find it virtually impossible to make it through the first few weeks without a drink, and these frequently break probation terms by failing to attend the Saturday meetings. In many cases they are again arrested for public drunkenness, and once again find themselves before the court. They find that the court's patience has not been exhausted. Rather than reverting to punishment, the probation officers will recommend the C-4 program if the individual still voices a desire to do something about his drinking problem.

The C-4 program would not have been possible without the wholehearted cooperation of the staff of the City Stockade. When the rehabilitation program was initiated, chronic drunkenness offenders sentenced to the stockade were permitted visits from A.A. members on a regular basis. But as the number of people in the stockade requesting help increased, the probation officers and the stockade staff decided it would be both convenient and desirable to set aside a special barracks for those who requested help. The barracks selected to be the rehabilitation barracks was number C-4, and "C-4" became the unofficial name for this aspect of the court rehabilitation program. Actually, the C-4 barracks is now only one of several barracks used to house the increasing numbers of men and women who are asking help with drinking problems.

The C-4 program quickly grew into a "prestige" program among the chronic drunkenness offenders who fill the courts and, to a large extent, the stockade. The small "luxuries" provided in the rehabilitation barracks—a few library books, some literature on alcoholism and Alcoholics Anonymous, first chance at work details which provide the men with cigarettes, etc.—carry a great deal of weight with the men. In addition, the rehabilitation barracks, which are designed to hold 40 persons, are limited to 20 persons, offering more room and comfort. The women's barracks are limited to 10 persons.

The barracks are something like treatment centers in themselves. Six times a week, A.A. members hold discussion meetings about the A.A. recovery program; the senior physician of the ARP clinic in Miami holds one group each week with the men, and one with the women; two Miami clergymen visit periodically to provide pastoral counseling; a counselor from the Division of Vocational Rehabilitation holds one session a week for each group; a movie on alcoholism is shown on Saturday night; and the probation counselor visits daily to work with the men in groups. In addition, the inmates spend a great deal of time

talking among themselves about the problems they face.

Sentences vary from 10 to 30 days, and after release from the city stockade, those who participated in the C-4 program are encouraged to attend the Saturday meetings of the court program, and participants in both programs are urged to join A.A. and to take advantage of a host of other community resources.

Any number of community resources are available to those who participate in either court rehabilitation program. The Salvation Army has made available to the court program six beds in their Red Shield Lodge. Needy individuals participating in the court program or being released from the C-4 program are offered free food and lodging at the Red Shield Lodge for one week if they will agree to take the first work call offered. However, they are expected to begin paying their own way ($1.35 per day for room and board) by the fourth day so that the six beds can be used to maximum advantage. In addition, the Salvation Army has offered space in which group therapy meetings could be held.

Other resources frequently used are: Vocational Rehabilitation services; the ARP Miami Clinic and the Avon Park Center; Traveller's Aid; Faith Farm; Protestant Welfare; Catholic Welfare; domestic and juvenile courts; probation and parole counselors; Goodwill Industries; the Florida State Employment Service; State Welfare; the Ministering Friends (a residence home for women); Manpower, Inc.; the Christian Brothers (free lunches); the Rescue Mission and the Salvation Army Social Center.

One of the notable attributes of the court program is the development of more positive attitudes toward chronic drunkenness offenders by court personnel, city jail personnel, police officers, stockade officials and staff, etc. A new interest is shown in what can be done to help these men and women avoid jail in the future. Jail personnel in particular have adopted a benevolent attitude toward the chronic drunkenness offenders; and the probation officers have reported stories about police officers explaining the rehabilitation program to people they have just arrested, so that before an individual is ever booked he is aware that the court is prepared to help him to help himself.

To help foster this attitude among new police officers, a class has been instituted in the Miami Police Academy to explain the philosophy and mechanics of the court programs. Police officers are beginning to view arrests as opportunities for the offender.

Philosophy of Rehabilitation

The effort being made in the municipal courts of Miami is in keeping with the philosophy of rehabilitation, rather than punishment, which has swept correctional institutions throughout the nation. It is helping to bring to the "drunk court" the qualities of mercy and justice which are absent in too many courts which deal with the chronic drunkenness offenders—courts which all too frequently ignore the dignity and needs of men while conforming with the letter of the law. With a $5,000 investment, the City of Miami has received national attention.

The Florida Alcoholic Rehabilitation Program has commended the City of Miami for its efforts, and urges every interested law enforcement officer and judge to learn more about what can be done to help the chronic drunkenness offender.

Birth of the Pitt County Alcohol Information and Service Center

BY LILLIAN PIKE

THE need for an alcoholism program in Pitt County was acutely felt as far back as 1955. At that time a Citizens Committee on Alcoholism was formed following a series of "interested citizens" meetings. Through the efforts of this committee, a plea for the acceptance of alcoholics as patients was made before the board of trustees of the county hospital. The attempt failed and the Citizens Committee on Alcoholism functioned only briefly. Apparently the time was not ripe for this type of community undertaking.

Spearheaded by the Pitt County Mental Health Association, concentrated effort with interested individuals and community groups resulted in the establishment of an Alcohol Information and Service Center.

The *need* for an alcoholism program in Pitt County, however, remained. It was again recognized in the spring of 1964 and the effort to establish a program was renewed, this time through the Pitt County Mental Health Association. The stage for action was set when Mrs. Helen Barrett, a new board member, was appointed chairman of the association's Committee on Alcohol by the president, Mrs. Ellen Carroll.

The Committee on Alcohol went to work and, before long, the chairman was ready with a plan for the establishment of a service center for the alcoholics of Pitt County and their families which she presented to the board of directors of the Pitt County Mental Health Association at its regular June meeting.

The plan included recognition of the need for such a center, stated its purpose, outlined objectives and the means by which to achieve them,

The Pitt County Alcohol Information and Service Center is unique among alcoholism programs in North Carolina because of its outgrowth from a mental health association. Alcoholism is properly a mental health as well as a medical, public health, individual and social problem. Sponsorship of the center by the Pitt County Mental Health Association appears, after eight months operation, to have placed alcoholism in perspective in the broad area of mental health without de-emphasizing its importance as a problem per se. Rather, alcoholism as a serious illness seems to have gained stature through the sponsorship. This article was prepared as a feature for *Inventory* from material submitted by the center's director.

provided for complete jurisdiction over the program by the association, and was complete with recommendations for staffing, operation of the office and method of financing. The plan was approved by the board of directors which voted to sponsor such a center if state and county approval could be obtained for the suggested method of financing.

The method of financing suggested was to take advantage of the permissive legislation set forth in North Carolina General Statute 122-71 which provides that local boards of Alcohol Beverage Control may spend up to five per cent of profits in support of community alcoholic rehabilitation and education. With the support of the local A.B.C. board, it would then be possible to obtain a two-year grant (budget permitting) from the community services fund of the Education Division, N. C. Department of Mental Health which was appropriated to help communities that have demonstrated an interest and have some local financial support to set up a community program on alcoholism.

Following the approval of the plan by the board, the chairman of the committee and the president of the association spent the summer of 1964 arranging and conducting conferences with key members of the association, interested citizens and members of the Pitt County A.B.C. Board in an effort to secure help and cooperation from the community. Dr. Norbert L. Kelly, director of the Education Division and state alcohol education leader, was then invited to address the board of directors on aspects of the plan.

The result of this concentrated effort in bringing together various groups and individuals was the determination that a center could be established. The subsequent allocation of funds by the local A.B.C.

It was determined through

board and a state community service fund grant enabled the Pitt County Alcohol Information and Service Center to open its doors on October 31, 1964, under the sponsorship of the Pitt County Mental Health Association, with Mrs. Helen Barrett as the first director.

The center has an advisory council of nine members who represent the association and the community. Its paid staff consists of a director and a secretary. All are responsible to the Pitt County Mental Health Association for the operation of the center.

The purpose of the center as stated in its by-laws is as follows:

". . . to give competent help to alcoholics and to their families, and to provide for the citizens of Pitt County effective alcohol education.

"To increase public understanding of alcoholism, its nature and treatment; to make this knowledge effectual in solving the problems of alcoholism; and the promotion of the principle that the alcoholic can be helped.

"These objectives shall be achieved by means of: a. Educational programs throughout the communities of Pitt County on the problems of alcoholism, the disease, and alcoholism, the public health problem; b. promotion of adequate hospital facilities in the area; and c. full cooperation with agencies dealing with related problems."

The original plan set forth the following goals and activities for the center:

1. Work for hospital facilities for the acutely ill alcoholic.

2. Inquire into the extent of alcohol education in the Greenville and

community effort that a center could be established.

Pitt County schools, making available speakers and materials, such as films, film strips, books and pamphlets.

3. Establish scholarships for teachers, educational, supervisory and other professional personnel to summer schools of alcohol studies in North Carolina and at Rutgers University.

4. Stimulate and aid church education of our youth on alcohol by providing speakers for youth groups, viewing films with groups and making materials available.

6. Provide educational materials for A.B.C. stores and public libraries throughout the county.

7. Provide library displays.

8. Develop an exhibit for county fairs and other exhibitions.

9. Work with East Carolina College by helping conduct workshops, providing research materials for students, furnishing speakers for social and professional fraternities and sororities when called upon to do so, and serve as liaison to individuals, including college students, seeking professional counseling and, also, those seeking information on the effects of alcoholism in the home.

10. Work with all agencies, channel information, contact facilities available, such as hospitals, both local and state, doctors, alcoholic centers, transitional homes and the Flynn Home.

11. Utilize the usual media for disseminating information including the press, radio, television and speakers bureau.

The center, from the time of its opening through June, 1965, made 57 referrals in behalf of 44 persons who sought its services. The referrals were made to the following: county hospitals (11), Alcoholics Anonymous (9), ministers (1), physicians (15), state mental hospital (8), Alcoholic Rehabilitation Center at Butner (3), Coastal Plains Mental Health Center (2), Flynn Home (4), psychiatric social worker (3), and a non-classified medical facility (1).

Forty-four educational programs were conducted which involved public health nurses, students and teachers of East Carolina College, adult and youth church groups, ministers, teachers and students of junior and senior high schools, teen-age clubs, book clubs, the Salvation Army, PTA's and radio and television stations.

The staff and members of the advisory council and/or association participated in 42 meetings—38 with local people, 2 program meetings of the Alcoholism Programs of North Carolina, and 2 meetings with another local council on alcoholism.

The advisory council met 7 times; the speakers bureau, four times; the board of directors, twice; and there was one meeting with the A.B.C. board.

Twenty-four planning meetings for a variety of reasons (including hospital facilities for alcoholic patients and the organization of a Negro A.A. group) were held with individuals and community groups. Programs were planned with guidance counselors, the Pitt Technical Institute, teenage clubs, recreation department, schools, churches and radio stations.

More than 2,157 pieces of literature were distributed to East Carolina College and students, welfare department, 4H Health Project, A.A., junior and senior high schools—students

(Continued on page 31)

As a community agency involved in a helping process, the alcoholism program's responsibility to the community is to learn to work through others who can get the job done.

THE ALCOHOLISM PROGRAM AND COMMUNITY RESPONSIBILITY

LAST year at the Summer School of Alcohol Studies I spoke of our work in New Bern. At that time the Craven County Council on Alcoholism had almost completed its first year of a project demonstrating a local council sponsorship of a psychiatric social service with an office in a local (county) hospital. Today, I want to speak again of this work because I feel it has made me more aware of some general principles involved in community responsibility. I hope to relate these principles to what we are doing in our local program.

First, let's take a look at ourselves. We are involved in a helping process with our communities. Since I am oriented as a social worker in this process, I feel I must take some self-inventory to understand myself as I relate to my work; to realize what I can or cannot do in keeping with my capabilities and limitations. Hopefully, as I am able to understand my own feelings and know myself, this same self-understanding can be used in the understanding of another. Certainly this is what takes place in working with an alcoholic.

The same principle, I feel, exists in community relationships. In other words, to be accepted and understood, I must see my community as my client. I must view others who work in this problem area in the same light. As a result of understanding the roles of others and making use of what they can do I feel I can be far more effective than if I attempt to do it all myself.

Sometimes in our zeal and dedication we are prone to want to become the "doers," with the result, oftentimes, that the more we do, the more we are expected to do and the less we really accomplish. Perhaps as a community agency involved in a helping process it is our responsibility to the community to become more and more a "don't do it yourself" group and learn to involve, and work through, others in our communities who actually can get the job done.

This principle has become quite real to me since I began working in New Bern. Our Executive Committee met monthly with the staff to hear our activity reports for the month. Our council met quarterly to review the same. In recent months we have begun to wise up to the fact that much of what we had been doing might have been done by those whom we sought to interest in our work. Now, we are trying to utilize the committee chairmen of various council activities either as coordinators or consultants.

BY PAUL KING

PSYCHIATRIC SOCIAL WORKER
CRAVEN COUNTY
COUNCIL ON ALCOHOLISM

Published by permission of the author, this article is based on a talk given at the 1965 Summer School of Alcohol Studies at the University of North Carolina, co-sponsored by the Education Division, N. C. Department of Mental Health, the Alcoholism Programs of North Carolina and the Health Education Department, UNC School of Public Health.

There is a need, of course, to be a doer at times, perhaps in initiating some new program or activity. Last year during the first year of the Psychiatric Social Service I felt the need to make, and made, numerous presentations in the community in order to learn the community and help the community to understand and accept the service. This past year, I have done considerably less of this. The service has been established and we have formed a Speakers Bureau to which the role of interpreter has been passed.

Frankly, I feel that we have learned this priniciple of working through others from our local mental health association which is fairly new. The budget of this group its first year, which has just been completed, was $6,000—enough to maintain an office two days per week with a part-time secretary. These interested citizens felt that they had to do the work since there was no full-time staff to call upon and have made far more effective use of volunteers and interested laymen in the overall mental health area than the council has with a budget of four times as much. Certainly, it is necessary to look to the future in planning for more personnel, but what they accomplished could not have been realized if they had thought only in terms of seeking more funds or having a larger staff. The effectiveness of enlarging one's program through involving lay people can not be denied.

In this same connection, I feel that in New Bern we have learned the importance of seeking not just the power structure group as council members but also including those who have the time and are willing to give of it. For every "Chief," several "Indians" are needed.

I believe we have made progress in eliminating some of the stigma of alcoholism locally by relating this problem to other problems in the community. We are getting away from going out in the community to make a talk on alcoholism per se by developing such subject topics as Alcoholism and Industrial Problems, Alcoholism and Child Development, Alcoholism and Public Health, etc. By using these related problems which the community has already generally accepted and acknowledged, the separation of alcoholism from other problems does not appear as great. I personally feel that we inadvertently add to the stigma which we strive to eliminate when we emphasize too much the uniqueness of alcoholism. In principle it is the same as if I, as a social worker, emphasized with my alcoholic patient the sense of difference which he is already feeling. By so doing, I would actually be "playing into" his illness that sense of difference which serves to block his own recovery. The same thing holds true with communities which, in a sense, have a "recovery" to make, too.

In my work I have felt this "sense of difference," which can so easily rub off on others, as I work with local facilities and professions. And much like the alcoholic "feels different from other people," we can

tend to feel that "we are not like other agencies." Some of this "sense of difference" can be lessened, as suggested earlier, by focusing our work through other people in related fields. An example would be working with welfare departments more in a consultant capacity rather than just receiving referrals from them. Another would be the health educator who learns to work through teachers in alcohol education rather than becoming directly involved with students. The area of coverage becomes much more broad in this way.

Since I am a newcomer to the community, having lived in New Bern about two years now, I am, perhaps, more concerned than some with how others view what I do as a social worker in this field. In a broader sense, I wonder how often we give thought to how others see us as a working group. So often we overlook the image we are creating. Think of the confusion, for example, that must exist among the citizens of our State when we come up with such names as Alcoholism Information Center, Alcoholic Information Center and Alcohol Information Center to describe a service in various communities which I am certain has the same basic functions and purposes. How misleading! There must be a tremendous difference between an *Alcohol* Information Center and an *Alcoholism* Information Center if we consider them in name only, and it is the name which initially impresses the community with our service. If we are able to see this difference, why isn't something done about our getting together on such a simple thing?

I feel that we often hinder our progress in this work and consequently add to the confusion in the community by sometimes becoming over-identified with one group. As

The relationship between

a result, our community tends to identify us with that group. Since so many of our local programs got started by the efforts of many who had recovered from alcoholism through Alcoholics Anonymous, I must use A.A. as an example of this. But if we are to grow in this work, I feel it is necessary that we move out and up from our earlier orientations and identify with *all* of our local agencies, not just those with whom we feel most comfortable. We can do this more quickly if we can see the *need* to do it.

Now, to be more specific about the Psychiatric Social Service of the Craven County Council on Alcoholism, let's consider the following background information:

Our community (85,000) is predominantly rural covering a tri-county area (Craven, Pamlico and Jones). There are also concentrations of marine servicemen and their families at the Cherry Point Marine Base located near New Bern.

Our council was organized to serve Craven County with the establishment of an Alcohol Information Center located in the downtown area of New Bern. In July, 1963, the Psychiatric Social Service was established and the area of coverage was extended to three counties. Office space was provided for the service by the Craven County Hospital without charge and is located two miles from the information center. Our staff includes an executive secretary and alcohol education teacher at the center and a psychiatric social worker at the hospital. A secretary is shared between the two offices which operate separately but are both directly

responsible to the council for their activities. Referrals are made to the service by the center.

The relationship of the service with the hospital is a most cordial and warm one. We feel fortunate in having a hospital administrator and staff who recognize the need for total treatment, medically and psychiatrically, and have provided for the admission of the acutely intoxicated patient. The care and management of these patients has been accomplished without any real problems during the past two years. This has been primarily due to the positive attitude of the hospital staff and the adoption of a "sitter system." When in the opinion of the attending physician, it is necessary to have someone with the patient during the acute phase of his treatment, we have developed a list of nursing personnel who are available for this duty during their off-shift and, when indicated, A.A. members.

The relationship of the service with the patient during this acute phase of treatment is mostly supportive. Occasionally, there are some patients requiring longer periods of hospitalization who become involved with psychiatric therapy. In these particular instances, a close relationship is especially maintained with the attending physician. Whenever possible, contact is made with relatives as soon as possible after the patient is admitted. So often, after the patient leaves the hospital, relatives do not come back to continue therapy so I feel it is crucial to begin their involvement at this time.

On the other hand, the patient does not become active in therapy until he is over the acute phase of his medical treatment. During his hospital stay, he is helped to understand the nature of the service and therefore has some idea of what is being offered prior to his release. The doctor aids us materially in preparing the patient to view our service as an adjunct to his medical treatment. A patient is never seen until the referral is made by the doctor. I am usually notified, however, when he is released and have the opportunity to prepare him to return on an out-patient basis.

We try to emphasize to all that we do not wish to use our hospital just to help someone to sober up. Yet I am sure this has often happened. It is now generally known throughout eastern North Carolina, for instance, that we accept alcoholic patients and they come to us covering a radius of at least 75 miles. It was not surprising to us when we saw so many female alcoholics coming from out of town to avoid the stigma of local censure.

At first there were several doctors whom we could count on to admit these patients and help them become involved with the Psychiatric Social Service. As time went on, other doctors began to participate and this was significantly noticed after the "sitter system" was developed. We have 33 doctors on our hospital staff and approximately one-half of them have referred alcoholic patients to us, either directly from their offices on an out-patient basis or during hospitalization. Another factor in this cooperation has been our furnishing of a social history on patients to the doctors who are realizing more and

more the importance of this information.

Since July 1, 1963, the service has received 326 referrals (hospitalized, 66; non-hospitalized, 260). The bulk of these referrals have come from doctors, relatives, the Alcohol Information Center and alcoholics. A lesser number have come from ministers, friends, welfare departments and the local mental health clinical service. There have been many instances in which the alcoholic was never seen after the spouse came in to get help for him and began therapy for herself.

Treatment is family oriented. The alcoholic is seen as a person with a problem and the label of being an "alcoholic" is never placed upon him until he is able to understand some of the dynamics of his behavior and his need to drink. Eventually, he begins to refer to his own alcoholism when he feels less the sense of difference separating him from other people. Family members are encouraged to understand their own needs as well as the adjustment of their roles within the home. Many wives are especially surprised, and often threatened, when some of the negative aspects of their own behavior are brought to light. This has occurred frequently when the male patient, for example, enters treatment at a state institution and the wife agrees to seek help while he is away. Individual and family therapy is offered during this time and the alcoholic is encouraged to use the service when he returns to the community.

Consultation is increasingly emphasized as has been mentioned. I feel most fortunate in being able to participate in the weekly staff conferences and in-service training programs of the Coastal Plains Mental Health Center in Greenville. My cases are reviewed with the staff of the center when evaluation by a complete staff are indicated. The proximity of this facility has helped in early detection and diagnosis of other mental illnesses associated with the use of alcohol.

In this paper, I have emphasized the Psychiatric Social Service since it is my primary area of responsibility in the overall operation of our council. We are now focusing attention on alcohol education in the schools of our area and have recently enlarged our staff for this purpose. This should provide us with a better balance of education, rehabilitation and treatment.

We are seeking new ways to involve more council members. A handicap which typifies small populated areas is that fewer people are available for community service. The ones already available are over-involved in many activities with limited time for each.

This past year we have worked closely with the local mental health association and jointly sponsored two workshops with them. Several of our council members hold a membership with the association and consequently some thinking is now being given to merging the two groups. Each could retain its identity in an Executive Committee and a greater number of citizens could participate in a joint, coordinated effort in mental health and alcoholism. I feel that this will eventually develop on the local level because the benefits are already being recognized.

The greatest challenge for growth in this field in my opinion is to continue to look for new ways to persuade the community to assume greater responsibility. New directions will be found and new solutions will emerge as we pool our varied resources in a unified effort.

ALTHOUGH the etiologies of alcoholism have not been fully established, it seems clear that a constellation of causes, varying in each individual case, is involved. These causes include metabolic, cultural, sociological, spiritual, psychological and other underlying factors. It can be safely stated that the various types of alcoholism cannot be explained adequately on the basis of self-imposed, habitual indulgence. Alcoholics are sick people who need and deserve professional help and a large proportion of those who can be motivated to seek help can be effectively rehabilitated. It is an oversimplification to say that alcohol is *the* cause of alcoholism.

Theories of Causation

While the misuse of alcohol is a common symptom found in all alcoholics, the problems are much more complex than can be adequately explained only by the effects of alcohol on metabolic systems of normal persons. Complicated interactions between psychological and physiological systems and alcohol metabolism are involved. Most psychological theories of the causes of alcoholism stem from the experience of professional observers who see patients revealing clear-cut pre-alcoholic personality and behavioral disorders and who fit into psychiatric diagnostic categories. To many psychologists and psychiatrists, the alcoholic's undercontrolled use of alcohol can be explained as symptomatic of pre-existent psychological defects.

Alcoholics appear to require more from alcohol than do other drinkers. Nevertheless, psychological investigations have failed to reveal a characteristic "alcoholic personality." Many of the psychological characteristics of the alcoholics as observed clinically can be explained as a result rather than causes of the condition. While further work in this area is very desirable it may be hypothesized that at least in some alcoholics

It can be safely stated that alcoholism cannot be explained adequately on the basis of self-imposed, habitual indulgence.

RESEARCH ON ALCOHOL PROBLEMS— A SURVEY OF THE PAST TEN YEARS

BY EBBE CURTIS HOFF, M.D.

Dr. Ebbe Curtis Hoff is medical director of the Division of Alcohol Studies and Rehabilitation, Department of Health, Commonwealth of Virginia, Richmond, Va.

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the causes may be ascribed to errors in development in the first few years of life. Alcoholics are often characterized as unusually dependent, sexually immature, inadequate, and having a low tolerance for unwanted feelings and tensions. They often experience severe degrees of depression, guilt, remorse and self-hatred. This may be due to defective endocrine function, early deprivation in childhood and other causes.

Sociocultural factors appear to be significantly related to the prevalence of alcoholism. Among these are attitudes towards drinking and drunken behavior. Recent studies correlate cultural acceptance of drunkenness with high alcoholism rates. Implicit in these observations is the premise that temperate use of alcohol, as distinguished from its excessive use, may reduce the likelihood of alcoholism. While psychological and sociocultural studies hold out great promise for the understanding of alcoholism it must also be said that the sociocultural approach to the treatment and prevention of alcoholism involves very drastic, sweeping and generalized reforms of attitudes and practices in society.

Metabolic theories of causation, on the other hand, suggest quite specific, if difficult, areas for study from which scientific data may be secured and which may accomplish more modest goals but nevertheless be quite helpful. The high tolerance to alcohol in the pre-alcoholic and the reduction of tolerance associated with the development of his illness suggests many experiments. With more sophisticated techniques biochemists may become increasingly able to identify abnormal ways in which the body of the alcoholic deals with alcohol.

It may well be that the breakdown of alcohol in the system of the alcoholic is different from that of the pre-alcoholic or the drinker who never becomes an alcoholic. Abnormalities in the metabolism of alcohol or its breakdown products may be responsible for the unusually damaging effects of alcohol ingestion in some people. Among the physiological-metabolic studies for which high hopes have been held and which still deserve further intensive study are investigations of the mechanism of brain damage in alcoholism as well as disturbances of endocrine function and liver metabolism.

Treatment

One of the most important research objectives in the field of treatment is to determine effective ways of motivating patients for therapy. Some progress has been made in this, especially in the past few years. These motivational efforts must include not only the patient and his family but also members of the therapeutic group and the community itself. Hopefully, advances in our understanding of the psychopathology and metabolic pathologies of alcoholism will lead to more specifically selected and applied therapeutic procedures.

At the present, there is a great array of treatment approaches, including the psychotherapies, drugs, metabolic reinforcement, group approaches, and spiritual and cultural guidance. In each of these categories, there is a wide variety of specific therapies. Some work has been done in an effort to correlate the success of these various therapeutic approaches with different diagnostic categories. Further work of this kind needs to be done. At present, it appears that the most effective approach to alcoholics is with those who can accept on-going therapy on a voluntary basis, the therapeutic plan including a broadly conceived

rehabilitation program to help the patient and his family in their community setting. Such therapy involves a therapeutic team working closely with the whole family. Clinics and hospitals are now applying many new or relatively new environmental or milieu settings—the so-called therapeutic community, day hospitals and other partial hospitalization plans such as night care.

The management of the acutely intoxicated alcoholic, thanks to newer drugs and other aids, is by no means as formidable a task as it was even ten years ago. It is important that the care of alcoholics not be simply episodic and applied only during periods of intoxication or withdrawal but that it be a continuing, on-going process.

Prevention

In the search for effective preventive methods, investigations of etiological factors are of utmost importance. Further studies are needed of alcohol metabolism and its effects, especially in relation to brain chemistry and function.

Also essential are sociocultural studies of alcohol use, prevalence of alcoholism and attitudes about alcohol and alcohol problems. Of great value should be the undertaking of longitudinal psychobiological studies of human subjects carried out to determine what chemical, psychological, social or cultural factors are related to alcoholism.

Even with our present knowledge, however, it seems to me that effective preventive education can be done; objective information about alcohol and its use should be made available to young people in schools as well as the public and also should be included in the curriculum of professional schools in the health sciences.

PITT COUNTY

CONTINUED FROM PAGE 23

and teachers—book clubs, health department, libraries, businesses, ministers, church groups, public health nurses, radio stations, Educational Planning Committee, the Salvation Army, guidance counselors and to citizens who requested material in writing and by telephone.

Thirty-eight packets of material, 32 of which went to members of the speakers bureau, were distributed and 7 books were placed with schools and a physician.

Over 2,260 pamphlets were distributed to the nine A.B.C. stores in the county.

Other activities included radio and television programs on the services of the center, the use of educational radio spot announcements, and newspaper articles. Sixteen films were previewed by the speakers bureau and many were used in the programs presented. Two scholarships were awarded for attendance at summer schools.

Never before have 44 Pitt County citizens troubled over their personal involvement with alcohol had recourse to a facility like the Pitt County Alcohol Information and Service Center. Never before has the community had so much concentrated exposure to information and facts about alcohol and the illness of alcoholism. Furthermore for eight months the Pitt County community has been *participating* in the process of taking a look at its alcohol problems and has been *involved* in efforts to find solutions to them. Participation and involvement are the essence of *true* education. Continued long-term effort is expected to bring about many changes for the benefit of the alcoholic, his family and the community.

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Competent Help Is Available At The Local Level

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†Mental Health Facilities

for
(Alcoholics and Their Families)

—Outpatient Treatment Services

‡Aftercare or Outpatient Clinics

for
(Alcoholics who have been patients of the N. C. Mental Hospital System)

—Outpatient Treatment Services

ASHEVILLE—

**Alcohol Information Center;* Mike Dechman, Educational Director; Parkway Offices; Phone: 252-8747.

†*Mental Health Center of Western North Carolina, Inc.;* 415 City Hall; Phone: ALpine 4-2311.

BURLINGTON—

**Alamance County Council on Alcoholism;* Margaret Brothers, Executive Director; Room 802, N. C. National Bank Building; Phone: 228-7053.

‡*Outpatient Clinic;* Alamance County Hospital; Hours: Wed., 9:00 a.m. - 4:00 p.m.

BUTNER—

‡*Aftercare Clinic;* John Umstead Hospital; Hours: Mon. - Fri., 9:00 a.m. - 4:00 p.m.

CHAPEL HILL—

†*Alcoholism Clinic of the Psychiatric Outpatient Service;* N. C. Memorial Hospital; Phone: 942-4131, Ext. 336.

**Orange County Council on Alcoholism;* Calvin Burch, Box 277, Carrboro.

CHARLOTTE—

**Charlotte Council on Alcoholism;* Rev. Joseph Kellermann, Director; 1125 E. Morehead St.; Phone: FRanklin 5-5521.

‡*Mecklenburg Aftercare Clinic;* 1200 Blythe Blvd.; Hours: Mon. - Fri., 8:00 a.m. - 5:00 p.m.

†*Mental Health Center of Charlotte and Mecklenburg County, Inc.;* 1200 Blythe Blvd.; Phone: FRanklin 5-8861.

CONCORD—

†*Cabarrus County Health Department;* Phone: STate 2-4121.

DURHAM—

‡*Aftercare Clinic;* Watts Hospital; Hours: Tues. and Fri., 2:00 - 5:00 p.m.

**Durham Council on Alcoholism;* Mrs. Olga Davis, Executive Director; 602 Snow Bldg.; Phone: 682-5227.

FAYETTEVILLE—

†*Cumberland County Guidance Center;* Cape Fear Valley Hospital; Phone: HUdson 4-8123.

GASTONIA—

†*Gaston County Health Department;* Phone: UNiversity 4-4331.

GOLDSBORO—

‡*Outpatient Clinic;* Cherry Hospital; Hours: Tues. and Fri., 10:00 a.m. - 12:00 noon. Thurs., 2:00 - 4:00 p.m.

**Wayne Council on Alcoholism;* H. B. Hulse, Executive Director; P. O. Box 1598.

GREENSBORO—

**Greensboro Council on Alcoholism;* Worth Williams, Executive Director; 216 W. Market St., Room 206 Irvin Arcade; Phone: 275-6471.

†*Guilford County Mental Health Center;* 300 E. Northwood St.; Phone: BRoadway 3-9426.

†*Family Service Agency;* 1301 N. Elm St.

‡*Outpatient Clinic;* 300 E. Northwood St.; Hours: Mon. and Thurs., 5:00-10:00 p.m.

GREENVILLE—

**Pitt County Alcohol Information and Service Center;* Helen J. Barrett, Director; P. O. Box 2371; 915 Dickinson Ave.; Phone: 758-4321.

†*Pitt County Mental Health Clinic;* Pitt County Health Department, P. O. Box 584; Phone: PLaza 2-7151.

HENDERSON—

**Vance County Program on Alcoholism;* Dr. J. N. Needham, Director; 2035 Raleigh Rd.; Phone: GEneva 8-4702.

HENDERSONVILLE—

Alcohol Information Center; S. Robertson Cathey, Director; 2nd Floor, City Hall; Phone: OX 2-8118.

HIGH POINT—

†*Guilford County Mental Health Center;* 936 Mountlieu Ave.; Phone: 888-9929.

JAMESTOWN—

**Alcohol Education Center;* Ben Garner, Director; P. O. Box 348; Phone: 883-2794.

LAURINBURG—

**Scotland County Citizens Committee on Alcoholism;* M. L. Walters, Executive Secretary; 308 State Bank Bldg.; Phone: 276-2209.

MORGANTON—

‡*Aftercare Clinic;* Broughton Hospital; Hours: Mon.-Fri., 2:00-4:00 p.m.

NEW BERN—

**Craven County Council on Alcoholism;* Gray Wheeler, Executive Secretary; 411 Craven St., P. O. Box 1466; Phone: 637-5719.

**†Psychiatric Social Service,* Craven County Hospital; Phone: 638-5173, Ext. 294; Hours: Mon.-Fri., 9:00 a.m.-5:00 p.m.

NEWTON—

**Educational Division, Catawba County ABC Board;* Rev. R. P. Sieving, Director; 130 Pinehurst Lane; Phone: INgersoll 4-3400.

PINEHURST—

Sandhills Mental Health Clinic; Box 1098; Phone: 295-5661.

RALEIGH—

‡*Aftercare Clinic;* Dorothea Dix Hospital, S. Boylan Ave.; Phone TEmple 2-7581; Hours: Mon.-Fri., 1:00-4:00 p.m.

†*Outpatient Clinic of the Mental Health Center of Raleigh and Wake County, Inc.;* Wake Memorial Hospital; Phone: 834-6484; Hours: Mon.-Fri.; 8:30 a.m.-5:30 p.m.

SALISBURY—

**Educational Division, Rowan County ABC Board;* Peter Cooper, Director; P. O. Box 114; Phone: 633-1641.

†*Rowan County Mental Health Clinic;* Community Bldg., Main and Council Sts.; Phone: MElrose 3-3616.

SANFORD—

†*Mental Health Clinic of Sanford and Lee County, Inc.;* 106 W. Main St.; P. O. Box 2428; Phone: 775-4129 or 755-4130.

SHELBY—

†*Cleveland County Mental Health Clinic;* 101 Brookhill Rd.; Phone: 482-3801.

SOUTHERN PINES—

**Moore County Alcoholic Education Committee;* Rev. Martin Caldwell, Director; P. O. Box 1098; Phone: OXford 2-3171.

WADESBORO—

**Education Division, Board of Alcohol Control;* Robert M. Kendall, Director; 125 W. Wade St.; P. O. Box 29; Phone: 694-2711.

WILMINGTON—

**Mental Health Center of New Hanover County;* 920 S. 17th St.; Phone: 763-7342.

**New Hanover County Council on Alcoholism;* Mrs. Margaret Davis, Executive Secretary; 211 N. Second St.; Phone: 736-7732.

WILSON—

‡*Aftercare Clinic;* Encas Station; Hours: Mon.-Fri., 8:00 a.m.-5:00 p.m.

†*Wilson County Mental Health Clinic;* Encas Rural Station; Phone: 237-2239.

WINSTON-SALEM—

**†Alcoholism Program of Forsyth County;* Marshall C. Abee, Executive Director; 802 O'Hanlon Bldg., 105 W. 4th St.; Phone: PArk 5-5359.

WISE—

**Warren County Program on Alcoholism;* Rev. A. T. Ayscue, Director; Box 100; Phone: 257-4538.

YADKINVILLE—

**Alcoholism Information Center;* Rev. James A. Haliburton, Director; Yadkin County Courthouse.

EDUCATION AND INFORMATION SERVICES

INVENTORY—bi-monthly magazine using the techniques of education in presenting facts about alcoholism in popular, illustrated style.

Films—on alcohol facts and personality health for distribution among groups interested in brief, factual motion picture studies. Obtainable from the Film Library, N. C. State Board of Health, Raleigh, N. C. Please request films as far in advance as possible and state second and third choices.

The ARC Brochure—illustrated booklet on North Carolina's program for treating alcoholism as an emotional sickness.

The New Cornerstones—Family manual giving basic facts about alcoholism and suggestions for coping with the personality sickness.

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Book Loan Service—kits containing reference books and pamphlets on alcoholism. Available to teachers from the Education Division, N. C. Department of Mental Health, Raleigh.

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These services are free upon request of citizens residing in North Carolina. For free materials in limited quantity, write

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